Frederick County Department of Aging
Meals on Wheels and Home Delivered Meal Service
Initial Application *Please Print clearly*

Name_____

Address_____Apt. #_____

Apartment Complex or neighborhood _____

City/State/Zip_____

Primary Phone_____ Date of Birth_____ Age_____

Secondary Phone_____ Email_____

Name/Relationship of Others Living In Home _____

Referred by _____Phone_____

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Personal Information

We request the following personal information for statistical purposes only. Providing it is optional and has no impact on your eligibility or participation in the Meals on Wheels / Home Delivered Meals program. This information is confidential.

____ Caucasian ____African American ____Native American/Alaskan ____Asian/Pacific Islander ____ Other_____ ____2 or more ____Decline to answer	___Hispanic ___Non Hispanic ___Declined _____Male _____Female _____Decline	_____Single _____Married _____Widowed _____Divorced _____Separated _____Unknown _____Decline	Are there pets in the house? _____Dog(s) _____Cat(s) _____Other Do you need assistance with acquiring pet food? **Yes / No**

Did you serve in the military? ___Yes ___No ___Decline to answer

Are You a Registered Voter? ___Yes ___No –would you like a form? **Yes / N**o **___Decline to answer**

Are there firearms or other weapons in the home? ___Yes ___No ___Decline to Answer

Please be advised that all weapons are required to be unloaded and stored in a safe and secure manner when volunteers and staff make meal deliveries and home visits. Failure to do so could result in immediate suspension or termination of service.

FOR OFFICE USE ONLY **AIM Case Number_____**

[date (mm/dd/yyyy) and initial as completed]

Referral Received _____ **Low / Medium / High** Priority (circle one)

Initial Screen Completed _____ Home Visit Completed _____

AIM Entry Completed_____ Nurse Review_____

MoW Log Entry Completed_____ Route Assignment_____

Mapping Completed_____ Service Initiated_____

Service Terminated _____

Initial Eligibility Screen *Please check all that apply*.

_____ Applicant is homebound. (i.e. unable to leave home without assistance)
_____Applicant is/may be at nutritional risk.
_____Applicant has no regular in-home care provider (volunteer or paid) to obtain/provide and/or prepare food on a regular basis.
_____Applicant is physically and/or cognitively unable to prepare meals.
_____Applicant can feed self and be alone safely for extended periods of time.
_____Applicant is aware of participant responsibilities and agrees to proceed with application.
_____Applicant is aware of meal cost and understands contribution policy.
_____Applicant is in need of temporary support for four weeks or less due to_____
_____Service would provide caregiver support for an elderly/disabled spouse or child who lives with applicant.
_____Service would provide caregiver support for a working spouse or child who lives with applicant.

Nutrition Screening

___Yes ___No Eats less than 5 servings of Fruits/Vegetables/Dairy products per day?
___Yes ___No Eats less than 2 meals per day?
___Yes ___No Has 3 or more alcoholic drinks per day?
___Yes ___No Has a dietary influenced illness?
___Yes ___No Has tooth/mouth problems affecting the ability to chew and eat?
___Yes ___No Has unintentional weight gain/loss of 10 or more pounds in the last 6 months?
___Yes ___No Lacks money to purchase food on a regular basis?
___Yes ___No Is unable to shop for or cook food on a regular basis?
___Yes ___No Uses 3 or more prescription and/or over the counter medications per day?
___Yes ___No Usually eats alone?

____ Number of Yes answers.

Diet Requirements:

___Regular Diet *(a heart healthy diet designed to be low in sodium, sugar and fat. This diet is suitable for most people, <u>including diabetics</u> who control their condition with diet and medication)*
___Diabetic Diet/Low Carbohydrate Diet*
___Mechanical Soft Diet*
___Low Fat Diet*
___Low Cholesterol Diet*
___Low Sodium Diet* Rx ____mg Na
___Other* _____

**A prescription is required from your health care provider. Please note, not all vendors are able to provide prescription diets.*

Does the applicant have any **<u>food allergies</u>*** ? Please specify _____

_____

**Vendors will make every effort to provide substitutes or eliminate these foods from client meals, but can not assure allergen free meals. Vendors are not able to accommodate special requests and food preferences.*

Health Conditions: *Please check all that apply.*

___Arthritis
___Cancer _____
___Depression
___Dementia
___Diabetes
___Developmental/Intellectual Disability
___Hearing Loss
___Heart Disease
___High Blood Pressure
___Mental Illness
___Respiratory Disease
___Traumatic Brain Injury
___Seizures
___Stroke
___Parkinson's Disease
___Post-Surgical _____
___Vision Loss
___History of Alcohol or Drug Abuse
___Other _____
___Other _____

Medications:
Please list all prescription and over the counter medications currently being used.

Medication	Dosage	Condition being treated	Notes

Primary Health Care Provider:

Name_____Speciality_____

Address_____

City_____ State_____ Zip_____ Primary Phone_____

Do you have any Allergies or other Health Information you would like us to know about?

_____

_____

_____

Emergency Contact #1 *-required*

Name _____Relationship _____

Address _____

City/State/Zip _____

Primary Phone # _____ Secondary Phone # _____

Email _____

Emergency Contact #2

Name _____Relationship _____

Address _____

City/State/Zip _____

Primary Phone # _____ Secondary Phone # _____

Email _____

Person Responsible for Financial Contributions toward Meal Cost

Name _____Relationship _____

Address _____

City/State/Zip _____

Primary Phone # _____ Secondary Phone # _____

Email _____

It is the participant and/or primary contact person's responsibility to assure current and accurate contact information is on file with the Department of Aging at all times. Changes should be reported within 24 hours to assure staff has the ability to reach clients and designated contacts quickly in the event of an emergency.

Agencies Currently Providing Assistance to Applicant:

Agency _____

Contact Person, Title _____Phone _____

Service(s) Provided _____

Agency _____

Contact Person, Title _____Phone _____

Service(s) Provided _____

Agency _____

Contact Person, Title _____Phone _____

Service(s) Provided _____

Financial Information and Benefits Screening:

If Single, is the individual's monthly income ____under or ____over $973* ____Declined

If a Couple, is their combined monthly income ____under or ____over $1311* *2014 Federal Poverty Guideline

Benefit	Are you currently enrolled?	Would you like additional information?	Was a referral made? Please specify to whom/date	Comments
Medicare/Medicaid/other health care insurance				
Medicare D (Prescription drug coverage)				
QMB/SLMB (Medicare A, B & D premium assistance programs)				
MEAP/ESUP (Energy Assistance programs)				
SNAP (supplemental Nutrition Assistance Program formerly known as Food Stamps)				
Senior Care (In Home Assistance program administered by the Department of Social Services				
Frederick County Homeowners Property Tax Credit				
MD Homeowners Property Tax Credit				
Renters Tax Credit				
Weatherization/Home Repair Assistance				
Veteran Services:				
Other:				

You may be eligible for additional benefits, services and assistance. A representative will contact you directly to discuss eligibility guidelines and application procedures.

The information provided on this application is true and accurate to the best of my knowledge. I agree to allow Frederick County Department of Aging staff to complete a home visit and evaluation prior to being approved for Meals on Wheels / Home Delivered Meals services.
I agree to allow Frederick County Department of Aging staff to share pertinent information as appropriate with other staff, family and caregivers, partner agencies, and with providers and agency representatives currently providing services to the applicant. I agree to notify the Frederick County Department of Aging if information on my application changes (i.e. new emergency contact, adding or reducing in-home aide service, etc).
I have read and understand the Meals on Wheels/Home Delivered Meals criteria for service, including the contribution policy and would like to be contacted by a Frederick County Department of Aging representative to continue the application process.

Print Name _____ Sign Name _____ Date _____

Return completed form to Frederick County Department of Aging by email to DeptOfAging@FrederickCountyMD.gov or Mail to Frederick County DoA/MOW, 1440 Taney Avenue, Frederick, MD 21702